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REPLY

Reply to Comment on: Patterns of transfer in labour and birth in rural New Zealand

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Dear Editor

We welcome the opportunity to respond to the three main issues raised by Professor Matsubara[1].

Professor Matsubara has correctly identified that our study[2] did not collect data on women who may have booked for birth at the rural unit but were transferred out of the model during their pregnancy. There is a very well developed antenatal screening process in place in New Zealand that requires the Lead Maternity Carer (LMC) to refer women with risk factors to an obstetrician, thus only low-risk women are eligible for care in rural or remote rural units[3,4]. Our focus was on the intrapartum transfer rate for women and babies eligible for intrapartum care and birth in a rural unit – that is, these were all low-risk women without identified pregnancy complications.

We note with interest that the intrapartum transfer rate (16.2%) in the additional study[5] Professor Matsubara identified concurs with that of our study (16.6%). This strengthens our findings concerning the rate of transfer - this information can now be more reliably discussed with women to enable them to make a truly informed decision about their intended place of birth; they will now be able to assess the likelihood that they may be transferred during labour.

The second issue raised was whether it was justifiable for midwives to care for women in remote areas, given that

urgent assistance is sometimes required. We agree that 'low risk' does not mean 'no risk', and that occasionally women and babies will require urgent care in the rural area. In New Zealand, midwife-led care is the dominant model of maternity care and to maintain a practicing certificate all midwives are required to undertake a biennial review of their practice against the Midwifery Council Standards[6] and are required to undertake, and successfully complete, courses designed to maintain currency in emergency, and other, clinical practice skills. Thus midwives, particularly those in rural areas, are well prepared to manage most emergency situations. In so doing they establish contact with appropriate specialist services and emergency transport teams. Antenatal emergencies occurring earlier in pregnancy, in both well women and those considered to be at risk, cannot be predicted. These women benefit from the skills, local knowledge and links with specialist teams established by the midwives and GPs resident in the rural area.

This collaborative relationship was described by Skinner and Foureur[7] in their study looking at the consultation, collaboration and referral patterns of New Zealand midwives. The study surveyed 645 midwives caring for a total of 4251 women. Results showed that the midwives consulted obstetricians for 35% of women in their care. Of those women, 43% were transferred to obstetric specialist care; and for 72% of this group, the midwives continued to provide the woman's care, with the support of the obstetrician. Clearly the high rate of transfer in the study by Hundley et al[5] confirms that for low-risk women, complications may still occur, and this finding aligns with the transfer rate and reasons for transfer in our study[2].

Third, with regard to perinatal morbidity or death associated with the women and babies transferred, these outcomes were not sought as part of this study. Given the rarity of neonatal death (and even more rare maternal deaths), few studies are powered to detect a significant difference in this outcome. However, choice of birth place has been shown to be significant in terms of women's exposure to unnecessary intervention. A recent New Zealand study by Davis et al[8]. found that for well women, near term, who planned to give birth at home or in a primary unit under the care of a midwife, there were significantly lower risks of caesarean section, assisted vaginal birth and intrapartum interventions than for those women who chose a secondary or tertiary hospital as their preferred place of birth. In terms of the welfare of the baby, this is central to a woman's thinking and decision-making. For rural women and their families, accepting a certain level of risk appears inevitable, given the distance from all specialist services, since accidents or acute illnesses may strike unpredictably. Thus, many women without any confirmed risk factors, will choose to birth locally. The associated costs and the loss of their immediate family support should they be required to relocate for birth, and for some, the risks of increased intervention associated with hospital care, are unacceptable.

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